Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DOCTORS HOSPITAL AT RENAISSANCE
5501 SOUTH MCCOLL ROAD
EDINBURG TX 78539

Respondent Name

AMERICAN HOME ASSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-06-7387-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please review the following date of service insurance is denying implants total cost on implants are $5,448.00 x 10% 544.80 = $5,992.80 please review for reconsideration."

Amount in Dispute: $5,992.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider has requested medical dispute resolution concerning what it considers to be implantables. The carrier disagrees. Rather, the provider has sought reimbursement for biological and putty, which are not of the hardware variety considered as implantables."

Response Submitted by: James R. Sheffield, III, FOL, 504 Lavaca, Suite 1000, Austin, TX 78701

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 31, 2005 through November 2, 2005	Inpatient Services –Rev Code 278-Implantables	$5,992.80	$5,992.80

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 TexReg 6264, sets out the reimbursement guidelines for inpatient hospital services.

3. This request for medical fee dispute resolution was received by the Division on August 3, 2006. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on August 10, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1-Workers Compensation state fee schedule adjustment.
   - 42-Charges exceed our fee schedule or maximum allowable amount.
   - 97-Payment is included in the allowance for another service/procedure.
   - Z656-Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review.
   - Paid according to state fee schedule guidelines. No additional allowance is recommended.

Findings

1. 28 Texas Administrative Code §133.307 (j)(2) states "The response shall address only those denial reasons presented to the requestor prior to the date the request for medical dispute resolution was filed with the division and the other party. Responses shall not address new or additional denial reasons or defenses after the filing of a request. Any new denial reasons or defenses raised shall not be considered in the review."

   The respondent states in the position summary that "The provider has requested medical dispute resolution concerning what it considers to be implantables. The carrier disagrees. Rather, the provider has sought reimbursement for biological and putty, which are not of the hardware variety considered as implantables."

   No documentation was found to support that the respondent raiseed this issue prior to the date the request for medical dispute resolution was filed; therefore, in accordance with 28 Texas Administrative Code §133.307 (j)(2), this issue will not be considered.
2. This dispute relates to inpatient medical services billed under revenue code 278-implantables provided in a hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.401.
3. 28 Texas Administrative Code §134.401(c)(1) states "Standard Per Diem Amount. The workers' compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows: Surgical $1,118."

   A review of the submitted medical bill indicates that the requestor billed for one surgical date.
4. 28 Texas Administrative Code §134.401(c)(3)(B), the reimbursement calculation formula is "LOS X SPDA = WCRA." Therefore 1 multiplied by $1,118.00 = $1,118.00.

   A review of the submitted EOBs supports reimbursement of $1,118.00 for inpatient surgical services; therefore, the requestor was paid in accordance with 28 Texas Administrative Code §134.401(c)(1) and (c)(3)(B).
5. 28 Texas Administrative Code §134.401(c)(4), states "Additional reimbursement. All items listed in this paragraph shall be reimbursed in addition to the normal per diem based reimbursement system in accordance with the guidelines established by this section. Additional reimbursement apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section."
6. 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)."

   On February 17, 2006, the respondent wrote the requestor in response to the request for reconsideration that "Paid according to state fee schedule guidelines. The implants listed are for bone grafting/biological materials included in the per diem rate." The requestor billed for these services under revenue code 278 and are reimbursable per 28 Texas Administrative Code §134.401(c)(4)(A).

   The requestor states in the position summary that "Please review the following date of service insurance is denying implants total cost on implants are $5,448.00 x 10% 544.80 = $5,992.80 please review for reconsideration." The requestor submitted cost invoices to support position that the total cost of implantables was $6,079.50. 28 Texas Administrative Code §134.401(c)(4)(A), allows for reimbursement at cost plus 10%; therefore, $6.079.50 plus $607.95 = $6687.45. The requestor is seeking dispute resolution for $5,992.80; this amount is recommended for reimbursement.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this

dispute, it is determined that the submitted documentation supports the reimbursement amount sought by the requestor. As a result, the amount ordered is $5,992.80.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $5,992.80 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature

		November 10, 2011
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.